BC CANCER
Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: SMAVPEM

DOCTOR'S ORDERS

Wt_____kg

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #(s) _____**

Date of Previous Cycle:

☐ Delay treatment _____ week(s). Dose delay for: _____

May proceed with doses as written if within 96 hours **ALT less than or equal to 3 times the upper limit of normal and bilirubin less than or equal to 1.5 times the upper limit of normal.** Creatinine **less than or equal to** 1.5 times the upper limit of normal *and* **less than or equal to** 1.5 X baseline.

Proceed with treatment based on blood work from: _____

PREMEDICATIONS: Patient to take own supply. RN / Pharmacist to confirm_____

For prior infusion reaction:

- ☐ **diphenhydrAMINE 50 mg** PO 30 minutes prior to treatment
- ☐ **acetaminophen 325 mg to 975 mg** PO 30 minutes prior to treatment
- ☐ **hydrocortisone 25 mg** IV 30 minutes prior to treatment ☐ **Other:**_____

TREATMENT: ☐ Repeat in three weeks

pembrolizumab 2 mg/kg x _____ kg = _____ mg (max. 200 mg)

IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter.

RETURN APPOINTMENT ORDERS

☐ Return in three weeks for Doctor and Cycle # _____

☐ Return in six weeks for Doctor and Cycle #s _____ and _____. Book for 2 cycles.

☐ Last cycle. Return in _____ week(s)

CBC & Diff, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH, creatine kinase prior to each treatment

If clinically indicated: ☐ **ECG** ☐ **Chest X-ray**

☐ **serum HCG or** ☐ **urine HCG** – required for woman of child bearing potential

☐ **Free T4 and free T3** ☐ **lipase** ☐ **morning serum cortisol** ☐ **serum ACTH levels**

☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH** ☐ **glucose** ☐ **troponin**

☐ **Weekly nursing assessment**

☐ **Other consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: